General Pharmaceutical Council

Registered pharmacy inspection report

Pharmacy Name: M&A Pharmacies Ltd, 2 Bridge Hill, Oughtibridge, SHEFFIELD, South Yorkshire, S35 0FL

Pharmacy reference: 1039261

Type of pharmacy: Community

Date of inspection: 26/11/2019

Pharmacy context

This community pharmacy is in the large village of Oughtibridge north of Sheffield. The pharmacy dispenses NHS and private prescriptions. And it supplies multi-compartment compliance packs to help people take their medicines. The pharmacy delivers medication to people's homes. And it provides the supervised methadone consumption service.

Overall inspection outcome

Standards not all met

Required Action: Improvement Action Plan

Follow this link to find out what the inspections possible outcomes mean

Summary of notable practice for each principle

Principle	Principle finding	Exception standard reference	Notable practice	Why
1. Governance	Standards met	N/A	N/A	N/A
2. Staff	Standards not all met	2.2	Standard not met	Not all pharmacy team members have a recognised training qualification. Neither are they on a recognised training course relevant to their role. This is not in accordance with GPhC minimum training requirements.
3. Premises	Standards met	N/A	N/A	N/A
4. Services, including medicines management	Standards not all met	4.2	Standard not met	The pharmacy doesn’t have suitable processes to manage the way it dispenses medicines into multi-compartment compliance packs. So, there is an increased risk of error. The pharmacy keeps records of deliveries it makes to people. But it doesn't always get signatures from people receiving their medicines. So, it doesn’t have a robust audit trail and cannot always evidence the safe delivery of people’s medicines.
5. Equipment and facilities	Standards met	N/A	N/A	N/A

Principle 1 - Governance ✔ Standards met

Summary findings

The pharmacy mostly identifies and manages the risks associated with its services. And it keeps most of the records it needs to by law. The pharmacy has written procedures that the team follows. The pharmacy team members respond adequately when errors happen. And they discuss what happened and they usually act to prevent future mistakes. The pharmacy team has some level of training and guidance to respond to safeguarding concerns to protect the welfare of children and vulnerable adults.

Inspector's evidence

The pharmacy had a range of standard operating procedures (SOPs). These provided the team with information to perform tasks supporting the delivery of services. Most SOPs had been reviewed in October 2019. The Superintendent Pharmacist and the pharmacy technician were reviewing the other SOPs. The SOPs did not name who had written them. The SOPs covered areas such as dispensing prescriptions and controlled drugs (CDs) management. The team had read most of the SOPs and signed the SOPs signature sheets to show they understood and would follow them. The pharmacy had up-to-date indemnity insurance.

On most occasions the pharmacist when checking prescriptions and spotting an error told the team member involved of their mistake. So, the person did not have the chance to identify their own error before correcting the mistake. The pharmacy kept records of these near miss errors. But the team did not record the error at the time it happened. The pharmacist left a note about the error for one of the regular pharmacists to record when they were next on duty. This ran the risk of the error not being recorded. And it did not give the team member involved the opportunity to reflect on what caused their error and the individual actions they would take to prevent similar errors in the future. A sample of the error records looked at found that the pharmacist recorded details of what had been prescribed and dispensed to spot patterns. And the pharmacist recorded what they thought caused the error and actions the team should take to prevent the error happening again. The pharmacy team recorded dispensing incidents. These were errors identified after the person had received their medicines. A sample of dispensing incident reports looked at found some included the reason for the error and the actions the team took to prevent the error happening again. One report detailed the supply of the wrong strength of a product. The report stated the dose had increased but the team member had generated the label from the electronic patient medication record (PMR) without referring to the prescription. The report explained that the team members were reminded to thoroughly check the labels against the prescription. Following other errors, the team had separated amlodipine 10mg and 5mg strengths as the packaging for both was similar.

The pharmacy had a procedure for handling complaints raised by people using the pharmacy. But it did not have a leaflet or poster to provide people with information on how to raise a concern. The pharmacy team used surveys to find out what people thought about the pharmacy. The pharmacy published these on the NHS.uk website.

The Responsible Pharmacist (RP) records looked at found several days did not have a record. At the time of the inspection the RP notice was wrong, this was corrected during the inspection. A sample of controlled drugs (CD) registers looked at found that they met legal requirements. The pharmacy did not regularly check the CD stock against the balance in the register. So, it may not to spot errors such as

missed entries. The pharmacy recorded CDs returned by people. Records of private prescription supplies, and emergency supply requests met legal requirements. A sample of records for the receipt and supply of unlicensed products looked at found that they met the requirements of the Medicines and Healthcare products Regulatory Agency (MHRA). The pharmacy had a folder containing documents about data protection and security including the General Data Protection Regulations (GDPR). The folder had a note attached asking the team to read the documents. But, there was no evidence of this. The pharmacy had a poster informing people of the confidential data it kept and how it protected this information. The pharmacy did not display a privacy notice in line with the requirements of the GDPR. The team separated confidential waste for shredding onsite.

The pharmacy team members had access to contact numbers for local safeguarding teams. And the pharmacy displayed information from Sheffield Safeguarding Children Board. The Superintendent Pharmacist was unsure if he had completed level 2 training from the Centre for Pharmacy Postgraduate Education (CPPE) on protecting children and vulnerable adults. The team had completed Dementia Friends training. The team had not had the occasion to report a safeguarding concern.

Principle 2 - Staffing **Standards not all met**

Summary findings

Most of the pharmacy team members have the qualifications and skills to provide the pharmacy's services. But not all team members have a recognised training qualification for their role. And they are not enrolled on a qualification training course. The team members support each other in their day-to-day work. And they share information and learning particularly from errors when dispensing. The pharmacy provides the team with some opportunities to complete ongoing training. But it does not give team members feedback on their performance. So, they miss opportunities to improve and suggest ideas to help the safe and effective delivery of services.

Inspector's evidence

The Superintendent Pharmacist and regular locum pharmacists covered the opening hours. The pharmacy team consisted of a full-time pharmacy technician, two part-time qualified dispensers, a part-time medicines counter assistant (MCA) and a part-time delivery driver. Two part-time members of the team involved with dispensing had not completed any recognised qualification training for the role. And were not enrolled on to a course. One of these untrained dispensers helped dispense the multi-compartment compliance pack and had been in post several years. This dispenser had been enrolled on to a course, but they had not completed the training and it had expired. The other unqualified dispenser had worked at the pharmacy since August 2019. Another team member had worked on the pharmacy counter for over a year and had not completed recognised qualification training. And was not enrolled on to an MCA course. This team member referred all requests for over-the-counter (OTC) products to the pharmacist before making the sale. At the time of the inspection, the Superintendent Pharmacist, the unqualified dispenser and the unqualified MCA were on duty.

The pharmacy provided limited extra training to the team. The team usually took opportunities of speaking to the representatives from companies selling OTC products who visited the pharmacy to discuss new products. The pharmacy did not provide the team with formal performance reviews. So, they didn't have a chance to receive feedback and discuss development needs. But occasionally the pharmacists gave the team informal feedback when examples arose. The pharmacy had a whistleblowing procedure. The pharmacy did not have targets for services such as Medicine Use Reviews (MURs). The pharmacist offered these services when they would benefit people.

Principle 3 - Premises ✔ Standards met

Summary findings

The pharmacy is clean, secure and mostly suitable for the services provided. And it has adequate arrangements for people to have private conversations with the team.

Inspector's evidence

The dispensary was small with limited work space. The dispensary work benches were cluttered, and the team used the floor space for storage. The pharmacy had separate sinks for the preparation of medicines and hand washing. The pharmacy had a small, sound proof consultation room. The team used this for private conversations with people. But the door into the room was blocked on both sides with boxes and packs of bottled water. The consultation room was untidy and cluttered with paperwork.

The premises were secure. The pharmacy had restricted access to the dispensary during the opening hours. The window displays detailed the opening times and the services offered. The pharmacy had a defined professional area. And items for sale in this area were healthcare related.

Principle 4 - Services **Standards not all met**

Summary findings

The pharmacy provides services that support people's health needs. And it manages most of its services adequately. But it doesn't have suitable processes to manage the way it dispenses medicines into multi-compartment compliance packs. So, there is an increased risk of error. The pharmacy delivers medicines to people's homes. But it doesn't ask people to sign for their deliveries. So, it doesn't keep a robust audit trail and cannot always evidence the safe delivery of people's medicines. The pharmacy obtains its medicines from reputable sources. And it mostly stores and manages medicines appropriately.

Inspector's evidence

Access in to the pharmacy was via a small step but there was no handrail. People requiring support to enter the pharmacy knocked on the door or opened the door and asked the team. The team used the internet to direct people to other healthcare services. The pharmacy kept a small range of healthcare information leaflets for people to read or take away. The pharmacy supplied methadone as supervised and unsupervised doses. And it prepared the methadone doses in advance before supply. This reduced the workload pressure of dispensing at the time of supply. The pharmacy kept the prescriptions in a dedicated folder in clear wallet labelled with the person's name. So, the team could easily locate the prescription.

The pharmacy provided multi-compartment compliance packs to help around 30 people take their medicines. People received monthly or weekly supplies depending on their needs. The pharmacy technician managed the service with support from the dispensary team. To manage the workload the team divided the preparation of the packs across the month. The team ordered prescriptions in time to deal with issues such as missing items. And the dispensing of the medication in to the packs. Each person had a record listing their current medication and dose times. The team dispensed the packs in an upstairs room away from the distractions of the main dispensary. The team did not keep the empty containers the medicines were removed from for the pharmacist to refer to when checking the packs. The team stored completed packs awaiting the pharmacist check unsealed and on top of each other. This ran the risk of medicines moving between the packs or the packs being knocked over. Sometimes the team brought the unsealed packs down the steep stairs to the main dispensary for the pharmacist check. This also ran the risk of losing medicines or the packs falling over. The pharmacist had bought a different type of pack that was more robust and was introducing these packs. The team recorded the descriptions of the products within the packs. And supplied the manufacturer's patient information leaflets.

The team members provided a repeat prescription ordering service. The team members kept a record of when they had requested the prescription, so they could identify missing prescriptions and chase them up with the GP teams. The pharmacy team were aware of the criteria of the valproate Pregnancy Prevention Programme (PPP). And stated there were no people prescribed valproate who met the criteria. The pharmacy did not have the PPP pack to provide people with information when required. The team asked people when they were first prescribed high-risk medicines such as warfarin to keep the team informed of details such as blood tests results and the medicine doses. The team did not always follow this up or record the information when it was provided. The pharmacy was undertaking an audit of people diagnosed with diabetes to check they had received eye checks and feet checks

within the last year.

The pharmacy provided separate areas for labelling, dispensing and checking of prescriptions. The pharmacy team used baskets when dispensing to hold stock, prescriptions and dispensing labels. This prevented the loss of items and stock for one prescription mixing with another. The pharmacy used CD and fridge stickers on bags and prescriptions to remind the team when handing over medication to include these items. The pharmacy had a system to prompt the team to check that supplies of CD prescriptions were within the 28-day legal limit. The pharmacy had checked by and dispensed by boxes on dispensing labels. These recorded who in the team had dispensed and checked the prescription. A sample looked at found that the team completed the boxes. When the pharmacy didn't have enough stock of someone's medicine, it provided a printed slip detailing the owed item. And the team sometimes kept the original prescription to refer to when dispensing and checking the remaining quantity. The pharmacy kept a record of the delivery of medicines to people. And asked people to sign for receipt of their medicines. But this only applied to controlled drugs. So, the team did not have evidence of the person receiving other medicines if the person queried this.

An unlabelled bottle containing liquid was found in an empty box of Oramorph 10mg/5ml oral solution. The team had no explanation for why the unlabelled bottle was in the box. This was given to the pharmacist to place in to the medicine waste bin. The pharmacy team checked the expiry dates on stock. But the team members could not find a record to show when they had done this. The team used a sticker with the expiry date written on to highlight medicines with a short expiry date. No out of date stock was found. The team members recorded the date of opening on liquids. This meant they could identify products with a short shelf life once opened. And check they were safe to supply. For example, an opened bottle of cetirizine oral solution with six months use once opened had a date of opening of 29 October 2019 recorded. The team recorded fridge temperatures each day. A sample looked at found they were within the correct range. The pharmacy had medicinal waste bins to store out-of-date stock and patient returned medication. And it stored out-of-date and patient returned controlled drugs (CDs) separate from in-date stock in a CD cabinet that met legal requirements. The team used appropriate denaturing kits to destroy CDs.

The pharmacy had no procedures or equipment to meet the requirements of the Falsified Medicines Directive (FMD). And there was no date set for when the pharmacy would have the equipment and computer upgrade to meet FMD requirements. The pharmacy obtained medication from several reputable sources. And received alerts about medicines and medical devices from the Medicines and Healthcare products Regulatory Agency (MHRA) through the post. The inspector directed the Superintendent Pharmacist to the option of receiving alerts via email, so the team could get this information quicker. The pharmacists actioned the alert and kept a record.

Principle 5 - Equipment and facilities ✔ Standards met

Summary findings

The pharmacy has the equipment it needs to provide safe services. And it mostly protects people's private information.

Inspector's evidence

The pharmacy had references sources and access to the internet to provide the team with up-to-date clinical information. The pharmacy used a range of CE equipment to accurately measure liquid medication. And used separate, marked measures for methadone. The pharmacy had a fridge to store medicines kept at these temperatures. The fridge had a glass door to allow the team to view stock without prolong opening of the door.

The computers were password protected and access to people's records restricted by the NHS smart card system. The pharmacy positioned the dispensary computers in a way to prevent disclosure of confidential information. The pharmacy stored completed prescriptions away from public view. And it held most private information in the dispensary and rear areas, which had restricted access. But the team kept some prescriptions and the CD registers containing people's confidential information on the table and shelves in the consultation room. People using the room for services could potentially view people's private information. The team used cordless telephones to make sure telephone conversations were held in private.

What do the summary findings for each principle mean?

Finding	Meaning
✔ Excellent practice	The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards.
✔ Good practice	The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services.
✔ Standards met	The pharmacy meets all the standards.
Standards not all met	The pharmacy has not met one or more standards.